Claims and Encounter Reporting

MIHS-HP Claims Department processes claims and encounters submitted by providers for service provided to MIHS-HP members.

All MIHS-HP providers must be registered with AHCCCS and have obtained an AHCCCS provider number before participating with MIHS-HP. Providers can reach AHCCCS at (602)271-4422.

Claims and encounter data must include the Provider ID and the appropriate suffix locator code to ensure accurate and timely processing. Claims submitted without this information may be delayed or denied.

Encounter Reporting

MIHS-HP requires (per AHCCCS, CMS, etc. regulations) providers to report all member encounters (episodes of member care), including capitated services. AHCCCS, in order to comply with federal reporting requirements, conduct data validation studies of member medical records to compare recorded utilization information to submitted encounter data.

Claim Forms

All claims for hospital services (excluding physician charges) must be submitted on a UB92 form. Professional services, transportation and durable medical equipment must be submitted on a CMS-1500 form. The CMS 1500 must reflect the ID number of the physician providing the service. All physician services must be billed on a CMS 1500, with the exception of hospital-based pathologist and hospital-based radiologist. Services for these providers may be billed on a UB92.

UB92 forms and CMS 1500 forms must contain the following information (*please refer to the individual health plan sections for specifics billing procedures specific to that health plan)*:

Ensure that claim forms are complete. A complete claim will include the following

- Accurate spelling of member's name
- Member address, phone number, and other demographic information, including sex and date of birth
- Member identification number, (Medicare number if applicable) and ensure accuracy of any other insurance numbers, including AHCCCS and MLTCP,
- Complete diagnosis and procedure codes including ICD-9 Diagnosis, ICD9 Procedure, CPT-4, and HCPCS Code (and DSM III/IV numbers for mental health diagnoses), including modifiers, if appropriate
- Provider number(s), suffix(es) as assigned by MIHS-HP, AHCCCS, Medicare
- Provider tax ID
- Date(s) of service
- Authorization number(s) for the date(s) of service

Medicare certified providers must include the name and address of their Medicare intermediary or carrier (per CMS regulations)

Claims and Encounter Reporting cont.

The claim form must indicate receipt of applicable co-payment (space 63 on the UB-92 and space 29 on the CMS 1500). If a provider chooses not to collect a co-payment, the amount must still be indicated.

Attach an explanation of benefits form or Explanation of Medicare benefits form to the claim when MIHS-HP is not the primary payor. MLTCP and MCHP are payors of last resort.

When more than one physician is involved in a member's hospital care, all physicians' bills should be reviewed simultaneously to correlate services and charges. Claims for inpatient services should be accompanied by pertinent hospital records including history and physical exam, discharge summary, consultants' reports, and operative/anesthesia records.

Instructions for Completing a CMS 1500

Field No.	Explanation
1. Program Block	Check appropriate box(es); MSSP member –check Medicare box, Group Health Plan (AHCCCS) and other if applicable.
1a. Insured's ID No.	Prior to recording, verify the member's member identification number (not PID number).
2. Member name	Enter member's complete name, as it appears on the member's member ID card.
3. Birth date & sex	Enter the month, day, and year of the member's birth and the member's sex.
4. Insured's name	Record the name of the member that corresponds with Field 1a (insured's ID number).
5. Member's address	Enter member's street address, city, state, and zip code and telephone.
6. Member relationship to insured	Enter as field designates.
7. Insured's address	Enter if Field 9 is completed.
8. Member's status	Check the appropriate boxes.
9. Other insured's name	If the member is covered by another insurance policy in addition to MIHS-HP, indicate the name of the individual who holds the insurance. If there is no other insurance coverage, enter N/A. Enter the member's name if the other coverage is in the member's name.

Claims and Encounter Reporting cont.

Instructions for Completing a CMS 1500 cont.

Field No.	Explanation
9a. Other insured's policy or group number	Enter the policy or group number of the member's other health insurance policy.
9b. Other insured's DOB	Enter the date of birth and sex of the individual listed in Field 9. Leave blank if there is no other health insurance coverage.
9c. Employer's name or school name	Record the name of the other insured's (Field 9) employer that provides the health insurance coverage for the individual identified as the insured in Field 9.
9d. Insurance plan name or program name	Enter the name of the other insured's health insurance organization plan name or program.
10. Is the member's condition related to:	If possibly a third party liability, type "Possible third party liability."
10a, b, c. Is member's condition the result of:	Check the appropriate box.
10d. Local use	Leave blank, not required.
11. Insured's policy group or FECA number	Record member's Medicare number.
11a. Insured's date of birth and sex	Enter insured's date of birth and sex, if member has Medicare coverage.
11b. Employer's name or school name	If the member is a Maricopa Senior Select Plan Member, type Aetna Medicare, P.O. Box 37200, Phoenix, AZ 85069.
11c. Insurance plan or program name	Type: HMO/CMP (plan/program name) if member has Medicare coverage.
11d. Is there another health benefit plan	Check appropriate box. If yes box is checked, complete items 9a-d.
12., 13. Member's or authorized person's signature	The member's, an authorized representative's signature, or a stamped or typed message saying, "consent for on file" is entered in Fields 12 and 13. These fields authorize the release of medical information to process the claim and payment of benefits to the provider.
14. Date that relates to an injury	If an injury, record date.

Claims and Encounter Reporting cont.

Instructions for Completing a CMS 1500 cont.

Field No.	Explanation
15. If member has had same or similar illness	Enter the first date by entering the month, day and year of the same or similar illness. The date entered in this item should be the same or later than the date shown in Field 24A.
16. Date member unable to work In current occupation	Provide the dates from (mmddyy) to (mmddyy) that the member was unable to work.
17. Name of referring physician or other source 17a. ID no. of referring physician	Enter the name and the 6 digit UPIN ID of the physician who referred the member. The UPIN number is not a physician identification number (called PIN) or a group practice number. CMS assigns the UPIN to a physician.
18. Hospitalization dates related to current services	When medical services are rendered as a result of, or subsequent to, a related hospitalization, enter the applicable month, day and year of the admission and the discharge.
19. Local use	Leave blank, not required.
20. Outside lab	Check "Yes", if a lab(s) was performed outside the MIHS-HP network or other than as stipulated in a MIHS-HP contract agreement. Enter the charge amounts.
21. Diagnosis or nature of illness	List first the ICD-9-CM code mainly responsible for the diagnosis condition, problem, or other reasons for the services. List additional codes in order of priority of co-existing conditions.
22. Medicaid resubmission code and ref. no.	Enter the appropriate code to indicate this claim as an adjustment, a void of a previous claim, or a resubmission of a previously denied claim: A – Adjustment of previously submitted claim. V - Void of previously submitted claim R – Resubmission of previously denied claim. Enter the original CRN along with the claim line in the field labeled "Original Reference No.". Claims to be voided or adjusted must have been paid. Adjusted claims must reflect original claim information and any additional information being billed. Do not submit a claim that has not been paid or denied.
23. Prior authorization number	Enter the MIHS-HP prior authorization number. See the Authorizations/Referrals section of the specific MIHS-HP plan for more information.

Claims and Encounter Reporting cont.

Instructions for Completing a CMS 1500 cont.

Field No.		Explanation
24a.	Dates of service	Enter the month, day and year on which the service began and ended.
24b.	Place of service (Required Field)	Enter the place of service code that describes where the services were provided. See page 11.22 of this section for list of POS codes.
24c.	Type of Service	Not required.
24d.	Procedure services or supplies	Enter the applicable CPT/HPCS codes, along with a brief description and, when applicable, modifiers to describe the procedures, services, or supplies for the dates of service (Field 24a) listed.
24e.	Diagnosis code	Relate the service provided to a diagnosis stated in Field 21 by entering the line number (1-4) of the diagnosis. If necessary to report more than one diagnosis reference for each procedure/service, enter in descending order of importance.
24f.	$ Charges	List the amount(s) that represent the charge for each service or procedure on the claim.
24g.	Days or units	Enter the days or units that represent each date of service for each procedure listed in Field 24d. Multiply Field 24f (charges) by Field 24g (days or units) to get the total charges (Field 28).
24h.	EPSDT	Not required. Leave blank.
24i.	EMG	(Emergency) Not required. Leave blank.
24j.	COB	(Coordination of Benefits) Not required. Leave blank.
24k.	Local use	Leave blank.
25.	Federal tax ID number	Enter the Federal tax ID number, Social Security number, or the EIN (Employer Identification Number) assigned to the provider for tax reporting purposes.
26.	Member's account number	Record the member's account number assigned by the physician or supplier's accounting system.
27.	Accept assignment	If Medicare applies, the participating provider checks the yes box. Payment is then made to the provider and not to the member.
28.	Total charges	Enter total charges.

Claims and Encounter Reporting cont.

Instructions for Completing a CMS 1500 cont.

Field No.		Explanation
29.	Amount paid	Record any amounts the provider has received as a co-payment or other applicable payment(s)/amounts the provider received from other insurance sources.
30.	Balance due	Subtract Field 29 from Field 28 to arrive at the amount entered in this field to determine balance due.
31.	Signature of physician or supplier, including credentials and date	Enter a legible signature of physician or supplier, or a representative, and the date the claim form was signed.
32.	Name/address of facility where services were rendered	Not required. Leave blank.
33.	Physician, supplier's billing name, address and phone number ID number (PIN #) Group ID number	Enter the name, address and phone number of the provider who rendered the service. Enter the service provider's 6-digit AHCCCS provider ID number. If payment is to be made to a group, attach the group's suffix number as assigned by MIHS-HP Provider Services, to the individual provider's PIN number.
If there are fields that are not applicable, leave the field blank. If you have questions regarding the CMS 1500 form instructions, please contact MIHS-HP Provider Services Department at 344-8957.		

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

APPROVED OMB-0938-0008

CARRIER

PICA

HEALTH INSURANCE CLAIM FORM

PICA

PATIENT AND INSURED INFORMATION

1. MEDICARE ☐ (Medicare #) MEDICAID ☐ (Medicaid #) CHAMPUS ☐ (Sponsor's SSN) CHAMPVA ☐ (VA File #) GROUP HEALTH PLAN ☐ (SSN or ID) FECA BLK LUNG ☐ (SSN) OTHER ☐ (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M ☐ F ☐

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self ☐ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street)

CITY | STATE

8. PATIENT STATUS Single ☐ Married ☐ Other ☐ Employed ☐ Full-Time Student ☐ Part-Time Student ☐

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code) ( )

ZIP CODE | TELEPHONE (INCLUDE AREA CODE) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES ☐ NO ☐

a. INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. AUTO ACCIDENT? YES ☐ NO ☐ PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES ☐ NO ☐

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES ☐ NO ☐ ***If yes***, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF CURRENT: MM DD YY ◀ ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES ☐ NO ☐ $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. ____ . __ 3. ____ . __

2. ____ . __ 4. ____ . __

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1												
2												
3												
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER SSN ☐ EIN ☐

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES ☐ NO ☐

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

PIN# GRP#

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)

PLEASE PRINT OR TYPE

FORM HCFA-1500 (12-90), FORM RRB-1500, FORM OWCP-1500

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND CHAMPUS PAYMENTS: A patient's signature requests that payment be made and authorizes release of any information necessary to process the claim and certifies that the information provided in Blocks 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient's signature authorizes any entity to release to Medicare medical and nonmedical information, including employment status, and whether the person has employer group health insurance, liability, no-fault, worker's compensation or other insurance which is responsible to pay for the services for which the Medicare claim is made. See 42 CFR 411.24(a). If item 9 is completed, the patient's signature authorizes release of the information to the health plan or agency shown. In Medicare assigned or CHAMPUS participation cases, the physician agrees to accept the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary as the full charge, and the patient is responsible only for the deductible, coinsurance and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary if this is less than the charge submitted. CHAMPUS is not a health insurance program but makes payment for health benefits provided through certain affiliations with the Uniformed Services. Information on the patient's sponsor should be provided in those items captioned in "Insured"; i.e., items 1a, 4, 6, 7, 9, and 11.

BLACK LUNG AND FECA CLAIMS

The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung and FECA instructions regarding required procedure and diagnosis coding systems.

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, CHAMPUS, FECA AND BLACK LUNG)

I certify that the services shown on this form were medically indicated and necessary for the health of the patient and were personally furnished by me or were furnished incident to my professional service by my employee under my immediate personal supervision, except as otherwise expressly permitted by Medicare or CHAMPUS regulations.

For services to be considered as "incident" to a physician's professional service, 1) they must be rendered under the physician's immediate personal supervision by his/her employee, 2) they must be an integral, although incidental part of a covered physician's service, 3) they must be of kinds commonly furnished in physician's offices, and 4) the services of nonphysicians must be included on the physician's bills.

For CHAMPUS claims, I further certify that I (or any employee) who rendered services am not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a contract employee of the United States Government, either civilian or military (refer to 5 USC 5536). For Black-Lung claims, I further certify that the services performed were for a Black Lung-related disorder.

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 424.32).

NOTICE: Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, CHAMPUS, FECA, AND BLACK LUNG INFORMATION

(PRIVACY ACT STATEMENT)

We are authorized by HCFA, CHAMPUS and OWCP to ask you for information needed in the administration of the Medicare, CHAMPUS, FECA, and Black Lung programs. Authority to collect information is in section 205(a), 1862, 1872 and 1874 of the Social Security Act as amended, 42 CFR 411.24(a) and 424.5(a) (6), and 44 USC 3101;41 CFR 101 et seq and 10 USC 1079 and 1086; 5 USC 8101 et seq; and 30 USC 901 et seq; 38 USC 613; E.O. 9397.

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by these programs and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal provisions that require other third parties payers to pay primary to Federal program, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records.

FOR MEDICARE CLAIMS: See the notice modifying system No. 09-70-0501, titled, 'Carrier Medicare Claims Record,' published in the Federal Register, Vol. 55 No. 177, page 37549, Wed. Sept. 12, 1990, or as updated and republished.

FOR OWCP CLAIMS: Department of Labor, Privacy Act of 1974, "Republication of Notice of Systems of Records," Federal Register Vol. 55 No. 40, Wed Feb. 28, 1990, See ESA-5, ESA-6, ESA-12, ESA-13, ESA-30, or as updated and republished.

FOR CHAMPUS CLAIMS: PRINCIPLE PURPOSE(S): To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services/supplies received are authorized by law.

ROUTINE USE(S): Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation consistent with their statutory administrative responsibilities under CHAMPUS/CHAMPVA; to the Dept. of Justice for representation of the Secretary of Defense in civil actions; to the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with recoupment claims; and to Congressional Offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate disclosures may be made to other federal, state, local, foreign government agencies, private business entities, and individual providers of care, on matters relating to entitlement, claims adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits, and civil and criminal litigation related to the operation of CHAMPUS.

DISCLOSURES: Voluntary; however, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information under FECA could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1128B of the Social Security Act and 31 USC 3801-3812 provide penalties for withholding this information.

You should be aware that P.L. 100-503, the "Computer Matching and Privacy Protection Act of 1988", permits the government to verify information by way of computer matches.

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Humans Services may request.

I further agree to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductible, coinsurance, co-payment or similar cost-sharing charge.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction.

NOTICE: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

Claims and Encounter Reporting cont.

Instructions for completing a UB-92 Claim

The UB-92 form must be used for billing hospital inpatient, outpatient, emergency room, hospital based clinic services, nursing homes, dialysis clinic, free standing birthing center, residential treatment centers (RTCs), comprehensive outpatient rehabilitation facilities (CORFs), and hospice services.

NOTE: All transportation services must be billed on a CMS 1500 claim form. Transportation services billed on a UB-92 will be denied.

UB92 claims can be obtained from:

Moore's Business Forms & Systems Division 800/634-7341
American Medical Association (AMA) 800/621-8335
National Business, Inc. 800/426-3167

The following specific information will be helpful when completing the UB92 form:

- Enter code 61 in Fields 24-30 "Conditions Codes", if submitting a UB92 for outlier considerations. Attach the backup documentation that supports your request for additional information.
- Ensure the Admission Type Field 19 matches the Revenue Code Field 42 and 43 (Revenue Description). Admission type 1 matches Revenue code 450 (emergency).
- The dates of service MUST match those on the referral that authorizes the service(s). Example: an authorization (referral number) issued for emergency room services cannot be used for the admission. The date of service is the same, but the service rendered will be different and requires a different authorization number.
- Field 46 – adding the units-of-service and recording it on the same line avoids a possible denial for duplicate claim/code, which can occur if the same revenue codes and HCPCS are recorded on multiple lines for the same service. Example: similar multiple procedures can be recorded on one line with the number of procedures recorded as units versus recording each procedure on a separate line with the same codes.
- A decimal point, followed by a digit must be used when recording a diagnostic code that specifies the use of a fourth or fifth digit. Example: 250.0 or 250.2 versus 250.
- All claims must be legible. Please submit hard-copy claims on an original claim form.
- **Submit claims to** :

  Maricopa Integrated Health Systems Health Plans (MIHS-HP)
  Attention: Claims Reception
  P.O. Box 20019
  Phoenix, Arizona 85036-0019

The following instructions for completion of the UB-92 (Exhibit III) should be used to supplement the information in the AHA Uniform Billing Manual for the UB-92.

Claims and Encounter Reporting cont.

NOTE: All bold type fields are required by MIHS-HP. Failure to complete these fields may result in a denial. A (*) next to a bold field indicates the information is required if applicable.

Instructions for completing a UB-92 Claim

***Required if applicable**

Field Name	Name/Status	Instructions
1	**Provider Data**	Provider name, address, phone number
2	Unassigned	Not required
3	**Member Control Number**	Account or bill control number assigned by the provider. AHCCCS will return this number as a cross-referrence on remittance advice and claims correction letters.
4	**Bill type**	Type of facility (1st digit), bill classification (2nd digit), and frequency (3rd digit). See AHA Uniform Billing Manual for codes.
5	**Federal Employer ID Number**	The Federal tax ID number is maintained in provider records.
6	**Statement Covers Period**	Beginning and ending dates of the billing period in a MMDDYY format.
7	**Covered Days**	Total number of days covered by a primary payer. If AHCCCS is the recipient's only coverage, leave the field blank.
8	Non-covered days	Total number of days covered by the primary payer. IF AHCCCS is the recipient's only coverage, leave the field blank.
9	**Coinsurance Days***	Enter the number of regular Medicare coinsurance days used during this billing period. Applicable only to Medicare crossover claims.
10	Lifetime Reserve Days	Enter the number of regular Medicare lifetime reserve days used during this billing period. Applicable only to Medicare crossover claims
11	**Group Provider ID***	Enter the name of the authorized group that bills and receives payment for services rendered by the service provider. Used for billing services, if payment is to be mailed to an address different from that of the service provider.

Claims and Encounter Reporting cont.

Instructions for completing a UB-92 Claim cont.

12	**Member's Name**	Enter the recipient's last name, first name, and middle initial as they appear on the Member ID card.
13	**Member's Address**	Enter the street address, city, state, and zip code.
14	**Member's birth date**	Enter the recipient's birth date in MMDDYY format.
15	**Member's sex**	Enter the recipient's sex as male (M), female (F), or unknown (U).
16	Member's marital status	Enter the recipient's marital status as married (M), single (S), unknown (U), widowed (W), divorced (D), or legally separated (X).
17	**Admit Date**	Enter admission date in MMDDYY format. Required for all inpatient, outpatient, and dialysis claims.
18	**Admit Hour***	Enter admission hour code. Required for all IP/OP claims. See UB92 Manual for codes.
19	**Admit Type**	Required for all IP claims. Emergency admits require a "1" for OP claims.
20	**Admit Source**	Enter code for admission source.
21	**Discharge Hour***	Required for IP claims. Enter the code to indicate the hour the member was discharged.
22	**Member Status***	Required for IP claims. Indicate the member's status for the billing period. See page 11.24 for list of Status codes.
23	Provider Medical Record	Enter the number assigned to the member's medical/health record.
24 – 30	**Condition Codes***	Enter the appropriate condition codes that apply to the bill. See page 11.24 for a brief listing of codes. See the AHA Manual for a complete listing of condition codes.
31	Unassigned	
32 – 35a. – b	Occurrence Code & Date	Enter the appropriate code(s). Enter date(s) as MMDDYY. See pg 11.25 for list of codes.
36a – b	Occurrence Span Code and Dates	Enter appropriate occurrence code from the listing on pg 11.25 and the corresponding FROM and THROUGH dates related to the occurrence in MMDDYY format.

Claims and Encounter Reporting cont.

Instructions for completing a UB-92 Claim cont.

37	**Internal Control Number***	Required on adjustment requests (Bill type xxx6). Enter the CRN assigned to the bill by AHCCCS and print "ADJUSTMENT" on the top of claim.
38 – 41	**Value Codes and Amount***	See page 11.25 for partial listing of codes. See AHA Uniform Billing Manual for complete listing.
42	**Revenue Code**	Refer to the AHA UB92 Uniform Billing Manual for revenue codes and abbreviations. Do not bill accommodation days on OP bill types. Bill revenue codes in chronological order for accommodation days and in ascending order for non-accommodation revenue codes.
43	**Revenue Code Description**	Refer tot he AHA UB92 Uniform Billing Manual for a description of revenue codes.
44	**HCPCS/Rates**	Enter the accommodation rate for IP bills and HCPCS code for all applicable ancillary services and OP bills. HCPCS codes are required for certain OP revenue codes. See Revenue-to-HCPCS Correlation Table on page 11.26.
45	**Service Date***	Enter the date of service, if different from the FROM-THROUGH date on the form.

Claims and Encounter Reporting cont.

Instructions for completing a UB-92 Claim cont.

46	**Service Units**	Enter the units of service provided. If accommodation days being billed, the number of units billed must be consistent w/the member status field (Field 22) and the statement covers period (Field 6).If the member has been discharged at the end of the billing period, AHCCCS covers the admission date **up to** the discharge date – does not include the date of discharge. If the member has not been discharged or did not recover, AHCCCS covers the admission date **through** the last date billed. Bill service units in whole numbers by rounding any fractions to the nearest whole number.
47	**Total charges by Revenue Code**	Multiply the units of service by the unit charged for each revenue code to determine the total charge. Each line, other than the sum off all charges, may include charges up to $999,999.99. Total charges are represented by revenue code 001 and must be the last entry in Field 47. Total charges on one claim can not exceed $999,999.99.
48	**Non-covered Charges***	When Medicare is the primary payor for dialysis and nursing home claims, bill AHCCCS for the actual cost of treatment and indicate the composite rate paid by Medicare in the prior payment field (Field 54). Enter any charges that are not payable by AHCCCS. The last entry in Field 48 is the total non-covered charges, represented by revenue code 001.
49	Unassigned	
50	Payer	Enter the name and ID number, if available, of each payer with full or partial responsibility for the charges incurred by the recipient for which the provider may receive reimbursement. AHCCCS must be the last entry.

Claims and Encounter Reporting cont.

Instructions for completing a UB-92 Claim cont.

51a-c	**Provider Number**	Enter the number assigned to the provider by the payer indicated in Field 50 a, b, or c.
52a-c	Release of Information	Enter "Y" if the provider has a signed, written consent from the member to release medical/billing information; otherwise, enter "R" for restricted or modified release, or "N" for no release.
53a-c	**Assignment of Benefits**	Not required.
54a-c	**Prior Payments***	Enter any reimbursement received from a payer(s) other than AHCCCS, including the member listed in Field 50. If reimbursement was not received, enter "0" to indicate that a reasonable attempt was made to determine available coverage for services provided. **Note: Enter ONLY actual payments received. Do not enter expected amounts from AHCCCS.**
55a-c	Amount due	Not required.
56	Unassigned	Not required.
57	Unassigned	Not required.
58a-c	**Insured's Name***	Enter the name of the insured covered by the payers listed in Field 50.
59a-c	**Member's Relationship to Insured***	Enter the relationship of the recipient to the insured.
60a-c	**Member Certificate, SSN-HIT number**	Enter the member identification number related to the payer in Field 50. The recipient's AHCCCS ID must be included and listed last. If there is any uncertainty regarding the AHCCCS ID number, contact the AHCCCS Eligibility Verification Unit.
61a-c	Group Name*	Enter Insured's group name, or "FFS" for members eligible for AHCCCS or ALTCS and are not enrolled in a plan.
62a-c	**Insurance Group Number***	Leave bland for fee-for-service recipients.

Claims and Encounter Reporting cont.

Instructions for completing a UB-92 Claim cont.

63a-c	**Treatment Authorization***	Enter the MIHS-HP prior authorization number for services that require prior authorization. Claims for services that require authorization will be denied it the number is not indicated.
64a-c	**Employment Status***	Enter the code from the list below that defines the employment status of the individual referenced in Field 58. 68. Employed full time 68. Employed part time 68. Not employed 68. Self-employed 68. Retired 68. Active military duty 9. Employment status unknown
65a-c	**Employer Name***	Enter the name of the Insured's employer.
66a-c	**Employer Location***	Enter the location of the Insured's employer.
67	**Principal Diagnosis Code**	Enter the principle ICD-9 code. **Note: The codes must match those on the authorization letter, if an authorization was obtained.**
68-75	**Other Diagnosis Codes***	Enter other applicable ICD-9 codes for all IP and OP visits. Include codes for other conditions that existed during the episode of care, but were not primarily responsible for the admission.
76	**Admitting Diagnosis Code***	Required for IP bills. Enter the ICD-9 diagnosis code that represents the significant admitting diagnosis.
77	**E-codes***	Enter the trauma diagnosis code, if applicable
78	**DRG**	Required field. Enter appropriate DRG.
79	Procedure Method Code	Enter "9" to indicated ICD-9 procedure codes. No other procedure codes are acceptable.
80	**Principle Procedure Code and Dates***	Enter the principle procedure code and date the principle procedure was performed during the IP or OP visit. ICD-9-CM procedure codes are required. If more than one procedure is performed, the principle procedure is related to the primary diagnosis, the definitive treatment performed for that condition, and requires the highest skill level.
81	Other Procedure Codes	Enter the procedure codes performed. Enter the codes in descending order of importance.

Claims and Encounter Reporting cont.

Instructions for completing a UB-92 Claim cont.

82	**Attending Physician ID**	Enter the AHCCCS ID number of the attending physician.
83	Other Physician ID	Enter the AHCCCS ID number of any assisting physician.
84	**Remarks***	Enter in remarks the previous claim reference number and indicate “Resubmission”, when applicable.
85	**Provider Representative**	An authorized hospital representative must sign each claim form verifying the certification statements on the reverse of the claim. Rubber stamp of facsimile signatures are acceptable but must be initialed by a provider representative.
86	**Date**	Enter the date the bill is submitted to the payer in MMDDYY format.

Claims and Encounter Reporting cont.

Claims Submission, Resubmission, and Denials

MIHS-HP intention is to process all clean claims according to AHCCCS and CMS rules and regulations and/or per contractual agreements. MIHS-HP processes all clean claims within thirty (30) working days of the date received. A claim is considered "clean" on the date of the following conditions are met:

- All required information has been received by MIHS-HP.
- The claim meets all submission requirements
- No errors in the data provided remain uncorrected.
- All required documentation has been provided.

Claims must be submitted to MIHS-HP within the following timelines:

MLTCP	Six (6) months
MCHP	Six (6) months
LTC to Residential	Six (6) months
Health Select	Six (6) months
MSSP	By 12/31 of the following calendar year
Other Plans	Six (6) months

MIHS-HP will deny processing of any claims received after the timely filing deadline. Contact MIHS-HP Claims Research at 602/344-8555, if you have questions regarding a claims remittance advice.

MIHS-HP assigns all received claims a Control Reference Number (CRN) that must be used when resubmitting a previously processed claim. MIHS-HP must receive resubmitted claims within one calendar year from the last date of service. A copy of the original claim form must be included for the processing of a resubmission.

Resubmissions/Adjustments

Claims that MIHS-HP may have denied in error (i.e. duplicate claim) or paid incorrectly, may be resubmitted. Resubmissions must be submitted as follows:

- Submit the claim in its original format. Do not submit for the difference
- Write in **red** ink on the claim "Not a Duplicate", "Incorrect Payment", etc
- List the original CRN in the appropriate box and indicate if this is a resubmission (no payment made) or an adjustment (paid incorrectly) by indicating an "R" for resubmission or an "A" for adjustment in the space preceding the CRN.
- Submit the claim with the appropriate Remittance Advice. Highlight on the remittance advice the claim in question and write in **red** ink the problem to be resolved, i.e., underpayment, never paid, etc.
- Include documentation that supports the request for corrected payment, i.e., a copy of pricing/compensation information, AHCCCS Cap Fee Schedule, or the agreement that applies to the amount to be paid
- Retain a copy and send the claim with the requested information

Claims and Encounter Reporting cont.

Nursing Facility Claims

MIHS-HP allows contracted nursing facilities to bill on-line, using the Direct Data Entry (DDE) system, or to submit hard-copy claims. **Please submit all nursing facility claims to:**

Maricopa Integrated Health Systems Health Plans (MIHS-HP)
Attention: Claims Reception
P.O. Box 20019
Phoenix, Arizona 85036-0019

Nursing facilities billing via the DDE system can access the system daily. Nursing facilities submitting hard copy claims are requested to submit during the first eight (8) days of the month.

MLTCP Claims: case managers are the only individuals with the authority to initiate and/or modify the MLTCP Service Authorization Form (SAF). Before submitting claims, contact the member's assigned case manager if the SAF requires any modifications. All claims submitted must have a copy of the SAF attached. The services billed must match the service and units authorized on the SAF or the claim will be denied.

Please contact 602/344-8873 with questions regarding the Nursing Home Error Report, reimbursement amount, or DDE System technical problems.

Medical Claims Review

All claims submitted to MIHS-HP are subject to Medical Claims Review. A medical review nurse in consultation with the MIHS-HP medical director will assess claims submitted for Medical Review. Claims will be assessed for medical necessity and appropriateness of level of care and/or changes.

MIHS-HP will review **all** claims against the following criteria:

- Verification of appropriate claims data completion;
- Verification of procedures as related to age, sex, and diagnoses;
- Verification of authorization for services and/or inpatient days;
- Check for duplication of services rendered;
- Determination of non-covered charges on hospital inpatient bills (items that are not medically necessary);
- Verification that modifiers have been used in appropriately (i.e., multiple procedures, assistant surgeons, etc.) and determine modifiers that are considered for payment vs. non-covered modifiers.

Please contact the MIHS-HP Claims Research Department at 602/344-8555, if you have questions regarding a claim denied as a result of Medical Review.

Claims and Encounter Reporting cont.

Claim Remittance Advice

MIHS-HP sends a remittance advice as an explanation of the claim(s) processing. The following information will assist in reading the remittance advice and determining the status of a claim:

1. Left hand side:
   - 1a. AHCCCS provider ID number w/suffix code (if applicable)
   - 1b. Provider's Name
   - 1c. Provider's Address
   - 1d. Provider identified in this area is the provider who rendered the service

2. Right hand side:
   - 2a. Remit date – the date the claim status was determined
   - 2b. Check number (if check was sent)
   - 2c. Payee ID – the ID number of the provider who rendered the service(s)
   - 2d. Payee Tax ID – The entity receiving payment

3. Remittance Advice heading for continued claim identification:
   - 3a. Service from through – the date is listed under the:
     - 3a1. Member's name
     - 3a2. Member's MIHS-HP identification number
     - 3a3. CRN Number – issued by MIHS-HP when the claim is received
     - 3a4. Ref (reference) number – the member's account number assigned by provider
   - 3b. Procedure code (outpatient services code) or Revenue Code (inpatient services code follows the date of service
   - 3c. The amount billed by the provider
   - 3d. The amount allowed by MIHS-HP
   - 3e. The amount paid by MIHS-HP
   - 3f. The Remarks section explains the status (encountered, paid, denied, and why) of the claim

4. The last page of the remittance advice includes totals for Amount Billed, Not Allowed, Allowed Amount, and the Amount Paid.

If the last (second or subsequent) remittance advice received states that the claim is a duplicate, locate the original and/or subsequent claim remittance(s). Checking all claim remittance(s) for the same date of service will assist in determining all reasons for the denials.

If a claim has been denied as a duplicate in error, please follow the guidelines for resubmitting a claims detailed under the heading **Claims Resubmission.**

Claims and Encounter Reporting cont.

Please contact the **MIHS-HP Claims Research Department at 602/344-8555**, if you have questions regarding the status of a claim or specific questions regarding items on the remittance advice. Please allow 30 days prior to contacting us for status of a claim.

Providers are responsible for notifying MIHS-HP in writing of any changes to their provider file. Failure to report changes may result in misdirected payments and correspondence. All changes to information on file must be signed by the provider or the provider's authorized agent.

Changes that must be reported include, but are not limited to:

- Addresses (correspondence, pay-to and/or service)
- Name (please include a copy of the letter advising us of the name change with supporting documentation)
- Ownership (this will require a new AHCCCS provider registration number and all supporting documentation).
- Group billing arrangements

Providers may also refer to the AHCCCSA Fee For Service (FFS) Manual found via the internet under the AHCCCS website (www.ahcccs.state.az.us/Publications/provman) or may obtain a copy by calling AHCCCS at (602) 417-4000.

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PROVIDER REMITTANCE ADVICE

123456 (1A)
ABC COMPANY (1B)
2516 E. UNIVERSITY (1C)
PHOENIX, AZ 85034 (1C)

(2A) REMIT DATE: 09-21-95
(2B) CHECK NBR: 1014460
(2C) PAYEE-ID 123456
(2D) PAYEE TAXID123456789

--SERVICE-- FROM	THRU	PRCDR REMARKS CODE	AMOUNT BILLED	ALLOWED AMOUNT	OTHER INSUR.	CO-PAY AMOUNT	OTHER/ DISCOUNT	AMOUNT PAID
MBR: JOHN SMITH (3A1)			A987654321 (3A2)					
CRN: 9519200256/3010/ (3A3)			REF# 999999 (3A4)					
1995								
		(3B)	(3C)	(3D)			(3E)	(3F)
06/16		99253	150.00	92.66			92.66	AMOUNT PAID
06/22		99263	135.00	66.39			66.39	AMOUNT PAID

PROVIDER TOTALS:

AHCCCS REIMBURSEMENT		MSSP REIMBURSEMENT	
AMOUNT BILLED	285.00	AMOUNT BILLED	000.00
NOT ALLOWED	125.95-	NOT ALLOWED	000.00
ALLOWED AMOUNT	159.05	ALLOWED AMOUNT	000.00
AMOUNT CAPPED	000.00	AMOUNT CAPPED	000.00
OTHER INSURANCE	000.00	OTHER INSURANCE	000.00
CO-PAYMENT	000.00	C0-PAYMENT	000.00
A-ADVANCE PAYMENT	000.00	A-ADVANCE PAYMENT	000.00
B-BONUS	000.00	B-BONUS	000.00
D-DISCOUNT	000.00	D-DISCOUNT	000.00
W-WITHHELD	000.00	W-WITHHELD	000.00
NEG BALANCE ITEMS	000.00	NEG BALANCE ITEMS	000.00

AMOUNT PAID 159.05

Claims and Encounter Reporting cont.

Place of Service Codes

11 - Office
12 - Home
21 - Inpatient Hospital
22 - Outpatient
23 - Emergency Room/Hospital
24 - Ambulatory Surgical Center
25 - Birthing Center
26 - Military Treatment Facility
31 - Skilled Nursing Facility
32 - Nursing Facility
33 - Custodial Care Facility
34 - Hospice
41 - Ambulance-Land
42 - Ambulance-Air or Water
51 - Inpatient Psychiatric Facility
52 - Psych. Facility Partial Hospital
54 - Community Mental Health Center
54 - Intermediate Care Facility/Mentally Retarded
55 - Residential Substance Abuse Treatment Facility
56 - Psychiatric Residential Treatment Center
61 - Comprehensive Inpatient Rehab. Facility
62 - Comprehensive Outpatient Rehab. Facility
65 - End Stage Renal Disease Treatment Facility
71 - State or Local Public Health Clinic
72 - Rural Health Clinic
81 - Independent Laboratory
99 - Other Unlisted Facility

Claims and Encounter Reporting cont.

Admission Types

Emergency: Member requires medical intervention for severe, life threatening or potentially disabling conditions. Documentation must be attached to claim. (1)

Urgent: The member requires immediate attention. (2)

Elective: The member's condition permits time to schedule services. An AHCCCS prior authorization number must be included in Field 63 of the claim. (3)

Newborn: The member is newborn. The newborn source of admission code must be entered in Field 20. (4)

Admit Source Codes

Adults and Pediatrics:

1. Physician referral
2. Clinic referral
3. Health plan referral
4. Transfer from hospital
5. Transfer from skilled nursing facility (SNF)
6. Transfer from other health care facility
7. Emergency
8. Courts/Law enforcement
9. Information not available

Newborns: (Refer to Field 19)

1. Normal birth
2. Premature birth
3. Sick newborn
4. Extramural birth

Claims and Encounter Reporting cont.

Patient Status Codes

01 Discharge to home or self care
02 Transferee to another short term general hospital
03 Transferred to a SNF
04 Transferred to an ICF
05 Transferred to another type of institution
06 Discharged to home under care of an organized home health service organization
07 Left against medical advice
08 Discharged/Transferred to home under care of home IV provider
20 Expired or did not recover
30 Still a patient
40 Expired at home (hospice only)
41 Expired in a hospital, SNF or ICF (hospice only)
42 Expired. Place unknown (hospice only)

Condition Codes

Special Program Indicator Codes.

- A1 EPSDT/CHAP
- A2 Physically handicapped children's program
- A3 Special federal funding
- A4 Family planning
- A5 Disability
- A6 PPV/Medicare 100% payment
- A7 Induced abortion-danger of life
- A8 Induced abortion-victim of rape or incest
- A9 Second opinion surgery
- 80 Children's Rehabilitation Services (CRS)
- 81 Indian Health Services
- 82 Arizona Neonatal Transport Program
- 83 Black Lung Program

PRO Approval Indicator Services

- C1 Approved as billed
- C2 Automatic approval as billed based on focused review
- C3 Partial approval
- C4 Admission/Services denied
- C5 Post-payment review applicable
- C6 Admission pre-authorization
- C7 Extended authorization

61 Cost outlier

Claims and Encounter Reporting cont.

Occurrence Codes

01	Auto accident
02	Auto accident/no fault insurance involved
03	Accident/tort liability
04	Accident/employment related
05	Other accident
06	Crime victim
24	Date insurance denied
25	Date benefits terminated by primary payer
27	Date home health available
42	Date of discharge

Value Codes

05	Professional component included in charges and billed to separate carrier
08	Medicare lifetime reserve amount in 1st year
09	Medicare co-insurance amount in 1st year
10	Lifetime reserve amount in 2nd year
11	Co-insurance amount in 2nd year
21	Catastrophic. Medicaid
22	Surplus. Medicaid
23	Recurring monthly income.
24	Medicaid rate code
45	Accident hour
46	Number of grace days
A1	Medicare Part A deductible
B1	Medicare Part B deductible
C1	Third party payer deductible
A2	Medicare Part A coinsurance
B2	Medicare Part B coinsurance
C2	Third party payer coinsurance

Claims and Encounter Reporting cont.

Revenue-to-HCPCS Correlation Table
ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM
Services Provided in General, Non-Federal Hospital Outpatient Settings

REVENUE-TO-HCPCS CORRELATION TABLE FOR UB-92 CLAIM FORMS		
UB-92 Revenue Codes	**Description**	**HCPCS**
070 - 219	Nursing Home and Inpatient Accommodation Charges	N/A
220, 221, 223-229	Special Charges	N/A
222	Technical Support Charge	Not allowed
230 - 239	Incremental Nursing Charge Rate	N/A
240 - 249	All Inclusive Ancillary	N/A
250 - 259 256	Pharmacy **Note:** 256 (Experimental Drugs) not covered by AHCCCS	Not allowed
260 - 269	IV Therapy	Optional: Q0081, 90784
27X	Medical/Surgical Supplies and Devices	
270 - 273		Not allowed
274	Prosthetic/Orthotic Devices	Required: AXXXX, E1350 G0020-G0021 LXXXX,VXXXX
275 - 279		Not allowed

Claims and Encounter Reporting cont.

Revenue-to-HCPCS Correlation Table cont.

REVENUE-TO-HCPCS CORRELATION TABLE FOR UB-92 CLAIM FORMS		
UB-92 Revenue Codes	**Description**	**HCPCS**
280 - 289	Oncology	Optional: Q0083, Q0084,Q0085 77299-77799 91105, 92002-92014 99201-99215 99241-99245 99271-99275 99356-99357
290 - 299	Durable Medical Equipment	N/A

Continued on next page.

Claims and Encounter Reporting cont.

Revenue-to-HCPCS Correlation Table cont.

REVENUE-TO-HCPCS CORRELATION TABLE FOR UB-92 CLAIM FORMS		
UB-92 Revenue Codes	**Description**	**HCPCS**
300 - 309	Laboratory	Required: 80000 - 89399 G0001, G0002 P3000, P3001, P7001, P9000 - P9022 P9603 - P9615 P9610, P9615 Q0095 - Q0098 Q0100- Q0102 Q0111- Q0116
310 - 319	Laboratory Pathological	Required: 80000 - 89399 P3000, P3001, P7001 P9000 - P9022 Q0095 - Q0098 Q0100 - Q0102 Q0111 - Q0116
320 - 329	Radiologic – Diagnostic	Required: 70000 - 79999
33x	Radiology – Therapeutic	
331, 332, 335	Chemotherapy - Injected, Oral or IV	Required: Q0083, Q0084, Q0085
330, 333, 339	Radiation Therapy / General / Other	Required: 70000 - 79999
34X	Nuclear Medicine	

Claims and Encounter Reporting cont.

Revenue-to-HCPCS Correlation Table cont.

REVENUE-TO-HCPCS CORRELATION TABLE FOR UB-92 CLAIM FORMS		
UB-92 Revenue Codes	**Description**	**HCPCS**
341	Nuclear Medicine - Diagnostic	Required: 78000 - 78999
342	Nuclear Medicine - Therapeutic	Required: 79000 - 79999
340, 349	Nuclear Medicine - General/Other	Required: 70000 - 79999
35X	CT Scan	
350 - 352	CT Scan	Required: Head: 70450 - 70488 Body: 70490 - 70492 71250 - 71270 72125 - 72133 72192 - 72194 73200 - 73202 73700 - 73702 74150 - 74170 76070, 76355 - 76380
359	Other CT Scans	Optional: 70450 - 76380
360 - 369	Operating Room Services	Surgery - **Required**: 10060 - 69979
370 - 379	Anesthesia	Not allowed

Claims and Encounter Reporting cont.

Revenue-to-HCPCS Correlation Table cont.

REVENUE-TO-HCPCS CORRELATION TABLE FOR UB-92 CLAIM FORMS		
UB-92 Revenue Codes	**Description**	**HCPCS**
380 - 389	Blood	Not covered
390 - 399	Blood Storage and Processing	Optional: 86006 - 86800
40X	Other Imaging Services	
400	General Classification	Required: 70000 - 79999
401	Diagnostic Mammography	Required: 76086 - 76091
402	Ultrasound	Required: 76506 - 79999
403	Screening Mammography	Required: 76092
409	Other Imaging Services	Required :70000-79999
410 - 419	Respiratory Services	Optional: 94010- 94799
421 - 429 (Detail required - 420 not allowed.)	Physical Therapy	Optional: 97010 - 97799 Q0086
431 - 439 (Detail required - 430 not allowed.)	Occupational Therapy	Optional: H5300

Claims and Encounter Reporting cont.

Revenue-to-HCPCS Correlation Table cont.

REVENUE-TO-HCPCS CORRELATION TABLE FOR UB-92 CLAIM FORMS		
UB-92 Revenue Codes	**Description**	**HCPCS**
441 - 449 (Detail required - 440 not allowed.)	Speech-Language Pathology	Optional: 92502 – 92599
450 - 459	Emergency Room	Surgery - **Required**: 10060 - 69979 Optional: 90783 - 90799 91105, 92002 - 92014 99201 - 99215 99241 - 99245 99271 - 99275 99281 - 99288, 99291 99354 - 99355
460 - 469	Pulmonary Function	Optional: 90410 - 94799
470 - 479	Audiology	Optional: 92502 - 92599
480 - 489	Cardiology	Optional: 92950 - 93799 93965 - 93971
490 - 499	Ambulatory Surgical Care	Surgery - **Required**: 10060 - 69979
500 - 509	Outpatient Services	N/A

Claims and Encounter Reporting cont.

Revenue-to-HCPCS Correlation Table cont.

REVENUE-TO-HCPCS CORRELATION TABLE FOR UB-92 CLAIM FORMS		
UB-92 Revenue Codes	**Description**	**HCPCS**
510 - 519	Clinic **Note:** 512 (Dental Clinic) not appropriate for UB-92; dental services should be billed on a CMS 1500 form	Surgery - **Required**: 10060 - 69979 Optional: 90782 - 90799 91105, 92002 - 92014 99201 - 99215 99241 - 99245 99271 - 99275 **99354 - 99355**
520 - 529	Freestanding Clinic	N/A
530 - 539	Osteopathic Services	N/A
540 - 549	Ambulance	N/A
550 - 559	Skilled Nursing	N/A
560 - 569	Medical Social Services	N/A
570 - 579	Home Health Aide (Home Health)	N/A
580 - 589	Other Visits (Home Health)	N/A
590 - 599	Units of Service (Home Health)	N/A
600 - 604	Oxygen (Home Health)	N/A
610 - 619	MRI	Required: 70336 - 76400
621, 622	Medical-Surgical Supplies (RAD)	Not allowed
63X	Drugs Requiring Specific Identification	
630-635		Not allowed

Claims and Encounter Reporting cont.

Revenue-to-HCPCS Correlation Table cont.

REVENUE-TO-HCPCS CORRELATION TABLE FOR UB-92 CLAIM FORMS		
UB-92 Revenue Codes	**Description**	**HCPCS**
636	Drugs/Detail Code	Optional: J0000-J9999 09920-09940
640 - 649	Home IV Therapy Services	N/A
650 - 659	Hospice Services	N/A
660 - 669	Respite Care (HHA only)	N/A
700 - 709	Cast Room	Surgery - **Required**: 10060 - 69979 Optional: 91105 92002 - 92014 99201 - 99215 99241 - 99245 99271 - 99275
710 - 719	Recovery Room	Surgery - **Required**: 10060 - 69979 Optional: 91105 92002 - 92014 99201 - 99215 99241 - 99245 99271 - 99275

Claims and Encounter Reporting cont.

Revenue-to-HCPCS Correlation Table cont.

REVENUE-TO-HCPCS CORRELATION TABLE FOR UB-92 CLAIM FORMS		
UB-92 Revenue Codes	**Description**	**HCPCS**
721 - 729 (Detail required - 720 not allowed.)	Labor Room / Delivery **Note:** 723 (Circumcision) subject to medical review	Surgery - **Required**: 10060 - 69979 Optional: 91105 92002 - 92014 99201 - 99215 99241 - 99245 99271 - 99275 99356 - 99357, 99360
730 - 739	EKG / ECG	Required: 93000 - 93350 93799
740 - 749	EEG	Required: 95805 – 95999
750 - 759	Gastro Intestinal Services	

Claims and Encounter Reporting cont.

Revenue-to-HCPCS Correlation Table cont.

REVENUE-TO-HCPCS CORRELATION TABLE FOR UB-92 CLAIM FORMS		
UB-92 Revenue Codes	**Description**	**HCPCS**
760 - 769	Treatment or Observation Room	Surgery - **Required**: 10060 - 69979 Optional: 90782 - 90799 91105, 92002 - 92014 99201 - 99215 99241 - 99245 99271 - 99275
790 - 799	Lithotripsy	Not allowed
800 - 809	Inpatient Renal Dialysis	N/A
810 - 819	Organ Acquisition	Not covered
820 - 829	Hemodialysis / OP or Home	Not allowed
830 - 839	Peritoneal Dialysis / OP or Home	Not allowed
840 - 849	Continuous Ambulatory Peritoneal Dialysis (CAPD) / OP or Home	Not allowed
850 - 859	Continuous Cycling Peritoneal Dialysis (CCPD) / OP or Home	Not allowed
881 - 899 (Exc. 882)	Miscellaneous Dialysis	Not allowed
882	Home Dialysis Aid Visit	N/A
890 - 899	Other Donor Bank	N/A
900 - 909	Psychiatric / Psychological Treatments	Optional: Q0082 90801 - 90899

Claims and Encounter Reporting cont.

Revenue-to-HCPCS Correlation Table cont.

REVENUE-TO-HCPCS CORRELATION TABLE FOR UB-92 CLAIM FORMS		
UB-92 Revenue Codes	**Description**	**HCPCS**
91X	Psychiatric / Psychological Services	
910 - 916 918, 919		Optional: 90801 - 90899
917	Bio Feedback	Optional: 90900 - 90915
92X	Other Diagnostic Services	
921	Perivascular Lab	Optional: 93720 - 93981
922	EMG	Optional: 95800 - 95999
923	Pap Smear	Optional: P3000, P3001
924	Allergy Test	Optional: 90782 - 90799 95004 - 95078, 95105 95115 - 95199 99201 - 99210 99241 - 99245 99271 - 99275
925	Pregnancy Test	Optional: 81025, 84702, 85703, Q0095
920, 929	Other Diagnostic Services	Any valid HCPCS

Claims and Encounter Reporting cont.

Revenue-to-HCPCS Correlation Table cont.

REVENUE-TO-HCPCS CORRELATION TABLE FOR UB-92 CLAIM FORMS		
UB-92 Revenue Codes	**Description**	**HCPCS**
941 - 949 (Detail required - 940 not allowed.)	Other Therapeutic Services	Optional: 91105 92002 - 92014 99201 - 99210 99241 - 99245 99271 - 99275
960 - 969	Professional Fees	N/A
970 - 979	Professional Fees	N/A
980 - 989	Professional Fees	N/A
990 - 999	Patient Convenience Items	Not covered